STATE OF TENNESSEE

DEPARTMENT OF COMMERCE AND INSURANCE

TENNCARE DIVISION

MARKET CONDUCT EXAMINATION
AND
LIMITED SCOPE FINANCIAL EXAMINATION

OF

OMNICARE HEALTH PLAN, INC.

MEMPHIS, TENNESSEE

FOR THE PERIOD APRIL 1, 2000 THROUGH JUNE 30, 2000

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DATE: November 9, 2001

SUBJECT: Limited Scope Financial Examination and Claims Processing Market Conduct Examination of OmniCare Health Plan, Inc.

An on-site limited market conduct examination of claims processing and a limited scope financial examination of OmniCare Health Plan, Inc., 1991 Corporate Avenue, 4th Floor, Memphis, Tennessee, 38132-1702, was performed in November 2000. The report of this examination is herein respectfully submitted.

I. FOREWORD

This report reflects the results of a market conduct examination report "by test" of the claims processing system of OmniCare Health Plan, Inc. (OHP). A description of the specific tests applied is set forth in the body of this report and the results of those tests are included herein. Further, this report reflects the results of a limited scope review of financial statement account balances as reported by OHP.

II. PURPOSE AND SCOPE

A. Authority

This examination of OHP was conducted by the TennCare Division of the Tennessee Department of Commerce and Insurance (TDCI) under the authority of Section 3-6.of the TennCare contract between the State of Tennessee and OHP, Executive Order No. 1 dated January 26, 1995, and Tenn. Code Ann. § 56-32-215.

OHP is licensed as a health maintenance organization (HMO) in the state and participates by contract with the state as a managed care organization (MCO) in the TennCare Program. The TennCare Program is administered by the TennCare Bureau within the Tennessee Department of Finance and Administration.

B. Areas Examined and Period Covered

The market conduct examination focused on the claims processing functions and performance of OHP. Fifty claims were selected for testing from paid and denied claims processed by OHP from April 1, 2000, through June 30, 2000. The fieldwork was performed from October 30, 2000, through November 10, 2000.

The limited scope financial examination focused on the balance sheet and income statement as reported by OHP on its National Association of Insurance Commissioners (NAIC) Quarterly Statement for the period ended June 30, 2000.

C. Purpose and Objective

The purpose of the examination was to obtain reasonable assurance that OHP's operations were administered in accordance with the TennCare Contract as well as state statutes and regulations concerning HMO operations, thus reasonably assuring that the OHP TennCare members receive uninterrupted delivery of health care services on an on-going basis.

The objectives of the examination were to:

- Determine whether OHP met its contractual obligations under its Contractor Risk Agreement with the State (the "TennCare contract") and whether OHP was in compliance with the regulatory requirements for HMOs set forth in Tenn. Code Ann. § 56-32-201 et seq.;

- Determine whether OHP had sufficient financial capital and adequate risk reserves to ensure the uninterrupted delivery of health care services for its TennCare members on an on-going basis;

- Determine whether OHP properly adjudicated claims from service providers and made payments to providers in a timely manner;

- Determine whether OHP had corrected deficiencies outlined in prior reviews of OHP conducted by the Comptroller or examinations conducted by TDCI.

III. PROFILE

A. Brief Overview

OmniCare Health Plan, Inc., formerly Affordable HealthCare Corporation, was chartered in the State of Tennessee on October 6, 1993, for the purpose of providing managed health care services to individuals participating in the State's TennCare Program. The Amended and Restated Bylaws of OHP, dated March 14, 1995, provided that the business will be conducted using the name OmniCare Health Plan, Inc.

On January 3, 1994, OHP contracted with the state as a preferred provider organization. On March 3, 1996, TDCI issued OHP a certificate of authority to operate as an HMO.

During the period under examination, OHP was licensed by TDCI to operate in the community service areas (CSAs) of Shelby County and Davidson County. OHP derives the majority of its revenue in the form of capitation payments from the state for providing medical benefits to TennCare members. As of June 30, 2000, OHP had approximately 46,000 TennCare members.

On June 29, 2001, TDCI approved OHP's request to materially modify its certificate of authority to expand its operations to include all CSAs that comprise the West

Tennessee Grand Region, to withdraw from the Davidson County CSA and to increase its TennCare enrollment to 85,000 enrollees. In July 2001, OHP had approximately 76,000 enrollees.

OHP has a management agreement with its parent company United America of Tennessee (UA-TN). During the examination period, this agreement required OHP to pay a management fee to UA-TN in the amount of 13 percent of gross revenues. Gross revenues includes all premiums collected by the management company on behalf of OHP as premium payment for health care services furnished by providers to members and interest earned on the invested idle funds of OHP.

B. Claims Processing Not Performed by MCO

During the examination period, OHP subcontracted with the following vendors for the provision of specific TennCare benefits and the processing and payment of related claims submitted by providers:

- MIM Health Plans, Inc., as its pharmacy benefits manager, and
- Doral Dental for dental services, and
- Block Vision for vision services.

Because subcontractors processed the claims for these benefits, claims for these types of services were not included in OHP's pool of claims from which claims were selected for detailed testing. Therefore, no pharmacy, dental or vision claims were tested for compliance with section 2-18. of the TennCare contract and Tenn. Code Ann. § 56-32-226(b) (the "Prompt Pay Act").

IV. PREVIOUS EXAMINATION FINDINGS - CLAIMS PROCESSING

The following were claims processing and internal control deficiencies cited in the examination by the Tennessee Department of Commerce and Insurance, TennCare Division, for the period June 1, 1999, through August 31, 1999, released January 11, 2000. OHP responded in writing to the findings on February 3, 2000.

Discrepancies in Claims Processing.

1. OHP did not process claims in the sample in accordance with the TennCare contract. Only 26% of "clean" claims in the sample were processed within 30 days, 70% of "clean" claims were processed within 40 days, and 98% of all claims in the sample were processed within 60 days. The TennCare contract requires an MCO to process

95% of "clean" claims within 30 days, the remaining 5% of "clean" claims within the next 10 days, and 100% of all claims within 60 days.

OHP's response: In order to insure claims are paid in accordance with the TennCare contract, OHP has purchased a new file server, which has in excess of three times the processing capacity and storage space of the server currently in use. The unit is being tested and should be fully operational by February 11, 2000. The additional capacity will allow all processes including claims adjudication and payment to be completed in less time. In addition, OHP has initiated the practice of paying claims at least three times monthly. Finally, the claims manager will notify the finance department of the oldest received date in the claims batches submitted for payment. This will allow accounting personnel to determine exactly how much time they have to complete the payment process to confirm to timelines in the TennCare contract.

2. Four of the 36 (11%) denied claims selected for testing were inappropriately denied.

   OHP's response: On February 7, 2000, the OHP claims department initiated the policy of requesting from Information Systems (IS) daily report of all claims denied each day. This report will be reviewed in detail to determine if claims are properly denied and that the denial reasons communicated to the provider were correct.

3. Eleven of the 36 (31%) denied claims selected for testing were appropriately denied, but one or all of the denial reasons communicated to the provider were incorrect.

   OHP's response: On February 7, 2000, the OHP claims department initiated the policy of requesting from Information Systems (IS) daily report of all claims denied each day. This report will be reviewed in detail to determine if claims are properly denied and that the denial reasons communicated to the provider were correct.

4. The paid amounts for three of the 14 (21%) paid claims selected for testing did not agree with the payment rates established by provider contract resulting in the providers being overpaid.

   OHP's response: The claims referred to were submitted and paid based upon a rate schedule from an existing contract. Subsequently, the contract was renegotiated and made retroactive to July 1, 1999, which was prior to the date the claims were adjudicated. Once the amended contract was executed, the new rates were entered and original payments were adjusted to reflect the correct rates. Unfortunately, this occurred after the TDCI visit.

5. The deductible and coinsurance policy applied is inconsistent with OHP's written policy in the member handbook. OHP has not requested or received written approval from the Bureau of TennCare or TDCI for changes to the enrollee benefits related to deductibles and coinsurance.

   OHP's response: This finding appears to refer to OHP's decision to waive deductible and coinsurance calculations prior to December 31, 1998. As TDCI noted effective January 1, 1999, OHP reinstated the calculation of coinsurance. OHP has continued to waive the calculation of deductibles. Effectively immediately, we will initiate the appropriate systems changes to calculate deductibles. The current year's edition of the member handbook will be edited to reflect these changes.

6. The current pend report indicates one claim in a suspend status for 76 days.

   OHP's response: The same provider noted in number 4 above submitted this claim. The claim was received on July 26, for services rendered after July 1, 1999. OHP was in the process of negotiating a new contract, which would be retroactive to July 1, 1999. An agreement was reached with the provider to delay payment of claims for this period until the new contract was finalized and the claims would pay at the correct rate. The claim was actually entered on the system September 28, 1999, suspended October 4, 1999 and was paid October 7, 1999. OHP considers this to be an isolated situation caused by the retroactive nature of the contract and should not occur in the future.

7. The explanation of benefits ("EOB") indicated enrollees are subject to a deductible, which is in conflict with OHP's current policy to waive the deductible calculation. Also, the family out-of-pocket accumulator was inaccurate for the EOBs tested.

   OHP's response: As stated in number 5 above, effective immediately, we will initiate the appropriate systems changes to calculate deductibles and make the appropriate changes to the member handbook. TDCI noted that the accumulation of enrollee's out-of-pocket cost was inaccurately accumulated on the four claims selected for testing. We will review appropriate EOBs in the future and insure that they reflect the correct amounts.

8. Four of the five (80%) totals for remittance advices selected for testing did not agree with the check amount due to delays between the print date of the remittance advice and the check. OHP prepares additional correspondence to reconcile the variance.

OHP's response: This problem will be solved with the implementation of the new file server which, due to the increase capacity will substantially reduce the length of time between the print date of the remittance advice and the check. We will continue to review the remittance advice and checks as they are processed and make any appropriate adjustments.

9. For eight of the 50 (16%) claims selected for testing, data elements from the claims were not entered or were entered incorrectly into OHP's claims processing system.

   OHP response: OHP has initiated a stringent audit process, which requires a minimum of 97% accuracy by each claims processor. There are specific procedures for employee education and discipline if these standards are not met.

10. OHP has not implemented an electronic billing option to providers for claims submission.

    OHP's response: OHP entered into a contractual relationship with a vendor to implement the electronic billing option in March 1999 at a substantial cost. Unfortunately, this project was not successful and we are currently in contact with another company, which has worked with providers and other managed care organizations to implement this product.

11. The weekly claims processing reports are missing required information concerning the performance of subcontractors. Also, some information regarding claims processed by OHP was considered inaccurate and unreliable.

    OHP's response: Request have been prepared to obtain this information from the appropriate subcontractors. A power outage had cause problems with the system prior to the TDCI visit. These problems have been correct.

12. A review of six provider complaints submitted to TDCI revealed most complaints were concerned with the timeliness of claims processing by OHP. One claim was found to have remained unpaid for 296 days. Also, system errors caused some claims to remain unpaid.

OHP's response: We believe that the implementation of the new server, the increase in the number of monthly claims payments and the daily review of denied claims will resolve this issue.

13. The claims received by OHP are not electronically controlled until the claims are actually entered into the claims processing system.

    OHP's response: OHP has purchased a scanner, which will be used to control electronically, the claims inventory.

14. As of October 4, 1999, claims inventoried in the mailroom and awaiting input into the claims processing system were 21 days old from the date of receipt.

    OHP's response: OHP has increased the number of claims payment to three monthly.

15. No reconciliation is performed to ensure that all claims received in the mailroom have been either processed by the claims system or returned to providers.

    OHP's response: OHP has purchased a scanner, which will be used to control electronically the claims inventory and insure that all claims received are recorded. A daily reconciliation is performed to ascertain that the total of processed and paid, suspended and denied claims equals the number of claims removed from inventory.

16. The claims policy and procedures manual does not reflect all current policies and procedures in the processing of claims.

    OHP's response: The claims manager has reviewed the policies and procedures manual to insure that it reflects current policies and procedures.

17. The provider appeals log is incomplete.

    OHP's response: OHP has designated an employee to review the appeals log periodically and make sure that it is complete and current.

18. The claims processing delays are increased due to the infrequency of check printing.

    OHP's response: OHP has increased the number of claims payments to three monthly. Claims will be paid weekly once the new server is operational.

V. SUMMARY OF PERTINENT FACTUAL FINDINGS

A. Summary of Deficiencies – Claims Processing Market Conduct Examination

The following deficiencies were determined to exist during the claims processing market conduct examination of OHP for the period April 1, 2000, through June 30, 2000:

1. The datafile provided by OHP could not be reconciled to the general ledger to within an acceptable limit.

2. OHP did not process claims in accordance with the TennCare contract. Ninety-six percent of all claims in the sample were processed within 60 days. The TennCare contract requires an MCO to process 100% of all claims within 60 days.

3. One of the 50 claims tested contained incorrect or missing data elements.

4. Three of the 50 claims tested were improperly denied.

5. OHP paid incorrect amounts for two of the 50 claims tested.

6. One claim was correctly denied, however; OHP's claims system indicated a paid amount.

7. The Claims Status Report submitted to TennCare on a weekly basis is not prepared correctly.

B. Summary of Deficiencies – Limited Scope Financial Examination

1. OHP's originally submitted NAIC Statement for the Quarter Ended June 30, 2000 understated claims payable by $811,661. The understatement resulted in a statutory net worth deficiency of $679,608 for June 30, 2000. UA-TN purchased $900,000 preferred stock in OHP to fund the statutory net worth deficiency.

2. The medical loss ratio reports filed through September 30, 2000 revealed several discrepancies. The Incurred But Not Reported (IBNR) component of the medical loss ratio report was not based on actuarial studies or previous historical payment patterns of medical claims. Administrative costs of $23,500 related to the claims processing fee of a pharmacy subcontractor was improperly included in the medical loss ratio report as medical expenses. Drug payments of $90,407 related to dates of service prior to July 1, 2000 were improperly included in the medical loss ratio report as medical expenses.

3. Subsequent to the examination period, OHP failed to notify TDCI that it had amended the management agreement with UA-TN. The amended management agreement is a modification of its certificate of authority and requires the prior approval of TDCI.

4. OHP incorrectly reported $252,222 in funds held in escrow by providers as an admitted asset. Under NAIC guidelines funds held in escrow are not readily available for the payment of claims and therefore should be classified as non-admitted assets.

5. Support for collection of $295,954 in accounts receivable due from providers was not provided and has been adjusted from net worth.

6. Premium revenues as of June 30, 2000 incorrectly includes amounts improperly accrued in premium revenue for the year ended December 31, 1999 that were never collected. Premium revenues of $6,200 have been adjusted from net worth.

VI. DETAIL OF TESTS CONDUCTED - CLAIMS PROCESSING SYSTEM

A. Claims Selected For Testing

OHP provided a data file of paid and denied claims for the period April 1, 2000, through June 30, 2000. The total amount paid per the data file **could not** be reconciled to OHP's general ledger to within an acceptable level. The data file could not be reconciled to the general ledger because OHP's personnel indicated that the data file was based upon their definition of "process date" which conflicts with definition of process date per the TennCare contract. Process date per OHP does not represent that a check has been cut or a remittance advice has been printed. **Pursuant to section 2-18 of the TennCare Risk Agreement, the term "process" means OHP must pay the claim or advise the provider that a submitted claim is (1) a "denied claim" and specify all reasons for denial or (2) a claim that cannot be denied or allowed due to insufficient documentation.** For each claim processed the data file included the date received, date paid and, if applicable, amount paid. From the data file, 50 claims were judgmentally selected from the denied claims.

Management's Comments:

Agreed. However, OmniCare Health Plan, Inc. has been able to comply with the 01/01, 04/01, and 07/01 data files as requested and provided an adequate reconciliation to the general ledger and will continue to do so in the future.

B. Julian Date Testing

A Julian date is assigned to an incoming claim to indicate the date the claim was received. Julian dates were tested to ensure that claims were being aged accurately for timeliness reporting. Ten (10) claims were randomly selected from a batch of incoming mail on October 30, 2000. All ten claims were entered into the claims processing system with correct received date.

C. Time Study of Claims Processing

1. The purpose of conducting a time study of claims is to determine whether claims were adjudicated within the time frames set forth in Section 2-18. of the TennCare contract. Section 2-18. requires an MCO to process 95% of "clean" claims submitted by both contract and non-contract providers within 30 calendar days of receipt, the remaining 5% of "clean" claims within the next 10 calendar days, and 100% of *all* claims (clean or not clean) within 60 calendar days. The term "process" means that the MCO must either:

   - Pay the claim (the MCO shall either send the provider cash or cash equivalents in full satisfaction of the clean claim, or give the provider a credit against any outstanding balance owed by the provider to the MCO);

   - Deny the claim, with ***all specific reasons*** for the denial communicated to the provider; or

   - Advise the provider that there is insufficient information to adjudicate the claim and detail the *specific* information needed to adjudicate the claim.

2. The processing and efficiency requirements of the TennCare contract were applied to the 50 claims tested. Clean claims were determined based on a definition provided by OHP. Of the 50 claims tested, 50 were identified as clean. For denied claims, the date that the provider remittance advice was printed was considered the final process date. Paid claims correctly reflected the provider remittance date as the final process date.

   OHP processed only 96% of clean claims selected for testing within 60 days from receipt of the claim and the contract requires 100%.

   The sample size used in this examination was not determined statistically; therefore, the results of the timeliness test for processing clean claims could not be projected to the total population of claims processed by OHP during the period April 1, 2000 through June 30, 2000. It could not be determined whether, during

the test period, OHP complied with the TennCare contract requirement to process 95% of clean claims within 30 days of receipt and the remaining 5% of clean claims within the next 10 days of receipt.

3. On January 25, 2001 and April 12, 2001 the TDCI requested a data file from all MCOs containing **all** claims processed during the months of January 2001 and April 2001 respectively. The data file was used to determine each MCO's compliance with the processing requirements defined in TCA § 56-32-226(b) and Section 2-18 of the TennCare Contract. Because these tests were performed on all claims processed in January 2001 and April 2001, no projections to the population are needed.

   During the month of January 2001, OHP processed 97.3% of all claims within 30 days and 99.93% of all claims within 60 days. During the month of April 2001, OHP processed 96.02% of all claims within 30 days and 99.57% of all claims within 60 days.

   TCA § 56-32-226(b) requires that 90% of clean claims be processed within 30 days and 99.5% of all claims be processed within 60 days. Section 2-18 of the TennCare contract requires that 100% of all claims be processed within 60 days. OHP was in compliance with TCA § 56-32-226(b); however, OHP was not in compliance with section 2-18 of the TennCare contract. It should be noted, however, that effective July 1, 2001, the timeliness requirements in the TennCare contract were changed to be consistent with those set forth in the Prompt Pay Act.

Management's Comments:

Agreed. However, during the month of January, 2001, OHP processed 99.93% of all claims within 60 days, during the month of April, 2001, 99.57% of all claims were processed within 60 days, and during the month of July, 2001, 99.72% of all claims were processed within 60 days.

D. Adjudication Accuracy Testing

The purpose of adjudication accuracy testing is to determine if claims selected were properly paid, denied, or rejected. Results of the adjudication testing are as follows:

1. The diagnosis code was incorrectly keyed for one claim tested.

   Management's Comments:

   This claim has been adjusted and processed correctly.

2. OmniCare's denial of three claims was improper:

   - One claim was denied "ineligible at date of service". The enrollee was TennCare eligible on the service date so the claim should not have been denied.

   - One claim was incorrectly denied for "no authorization". This service was performed for a newborn. Per the TennCare contract, all newborn services are medically necessary. According to TennCare contract Section 2-3.m.3, the MCO cannot deny because of a lack of authorization when the enrollee is retroactively enrolled in the HMO.

   - One claim was denied as "not a covered benefit"; however, the service had been prior authorized by OHP.

   Management's Comments:

   The three claims in question have been adjusted and processed correctly.

3. Two claims paid incorrect amounts.

   - One claim should have paid $17.91, but the actual amount paid was $17,391.

   - One claim should have paid $1,100, but the actual amount paid was $11,000.

   Management's Comments:

   These two claims were processing errors and have been corrected and overpayments recouped.

4. One claim was correctly denied, however; OHP's claims system indicated a paid amount.

   Management's Comments:

   Agree. This happens in the system if the claim is adjudicated before it is corrected. The remittance advice, however, shows the claim as rejected with $0.00 amount paid.

E. Withhold, Deductible and Coinsurance Testing

1. The purpose of "withhold testing" is to determine whether amounts withheld from provider payments are in accordance with the provider contracts and are accurately calculated. OHP does not withhold a certain percentage of payments from providers.

2. The purpose of testing deductibles and coinsurance is to determine whether enrollees are subject to out-of-pocket payments on certain procedures, whether out-of-pocket payments are within liability limitations, and whether out-of-pocket payments are accurately calculated in accordance with Section 2-3.k. of the TennCare contract.

   No discrepancies were noted during the claims test work.

F. Pended/Unprocessed Claims Testing

The purpose of testing suspended claims is to determine the existence of claims that have been pended by OHP, the principal reasons for the pended claims, the number of pended claims that are over 60 days old, and whether a potential material unrecorded liability exists because of pended claims. OHP provided the examiners with a pended claims report for each claim type (HCFA1500 and UB92) as of October 28, 2000. A total of 20 pended claims were reported. Two claims were unprocessed for more than sixty days. As a result, OHP was not in compliance with Section 2-18 of the TennCare contract, which requires all claims to be processed within 60 days. Claims in pend status include new claims that have not been adjudicated and claims that have been previously been adjudicated and are reopened for adjustment. Adjusted claims do not used a new claim number. The oldest claim on the pend report was received September 22, 1999. The claim had been adjudicated and then later pended for an adjustment. Most claims on the pend report were less than 30 days old. These facts, in combination with the minimal number of claims in excess of 60 days old, does not indicate that a potential unrecorded material liability existed as a result of pended claims.

G. Explanation of Benefits ("EOB") Testing

The purpose of EOB testing is to determine whether uninsured and uninsurable members (non-Medicaid) who are subject to deductibles and coinsurance are provided an explanation of benefits in accordance with usual and customary health care industry practices.

OHP provides EOBs to enrollees whose claims are subject to cost sharing. The EOBs corresponding to the five claims tested previously for correct deductible and coinsurance calculations were requested. No discrepancies were noted during the review of EOBs.

H. Remittance Advice Testing

The purpose of testing remittance advices is to determine whether remittance advices sent to providers accurately reflect the processed claim information in the system.

The examiners requested five remittance advices for testing. The totals of the remittance advices for the five tested agreed with the check amount.

I. Analysis of Canceled Checks

The purpose of analyzing canceled checks is to: (1) verify the payment of claims by OHP; and (2) determine whether a pattern of significant lag times exists between the issue date and the cleared date on the checks examined.

The examiners requested 5 checks for testing. All 5 checks cleared through the bank account within a reasonable time after the issue date and the check amounts agreed with the amounts paid per the remittance advices.

J. Comparison of Actual Claim with System Claim Data

The purpose of comparing the data on the hard copy claims to the data entered into the claims system is to ensure that the claims data received by OHP is accurately entered into the claims system. Data must be entered accurately to ensure that claims are adjudicated appropriately and that encounter data is reported correctly to the TennCare Bureau.

The examiners requested the 50 original claims selected for testing. OHP provided 50 claims. The data elements from the 50 claims were compared to the data elements entered into OHP's claims processing system. Results of the comparison testing are as follows:

- The diagnosis code was incorrectly keyed for one claim tested.

- The billed amounts for two claims were entered incorrectly which resulted in these claims being overpaid. (See VI.D.3. above)

K. Electronic Claims Capability

Section 2-18 of the TennCare contract states, "The CONTRACTOR shall have in place a claims processing system capable of accepting and processing claims submitted electronically with the exception of claims that require written documentation to justify payment ..." Section 2-2.g. of the TennCare contract required the MCO to move to electronic billing no later than January 1, 1997. The electronic billing of claims allows the MCO to process claims more efficiently and cost effectively. OHP is in the process of implementing an electronic billing option for claims submission by providers.

VII. REPORT OF OTHER FINDINGS AND ANALYSES - CLAIMS PROCESSING

A. Weekly Claims Processing Reports

The October 13, 2000 weekly claims processing report was selected for review and OHP was requested to provide supporting documentation for this report. The following deficiencies were noted in the weekly claims processing report:

- OHP failed to report subcontractor claim data. Pended vision and pharmacy claims were not reported and average turnaround times for adjudicated vision and pharmacy claims were not reported.

- OHP did not report the number of provider complaints received in writing or by phone. A provider appeal listing was obtained that indicated 6 provider appeals were filed with OHP during the week of October 13th and, as of November 10, 2000, three of the six appeals remained unresolved.

Management's Comments:

The report has been corrected and is now being filed properly.

B. Claims Processing Manual

The claims processing manual states "… any suspected fraudulent billing will first be brought to the attention of the provider of service. If inappropriate billings procedures are not discontinued, the Memphis Area Medical Fraud Department of the Federal Bureau of Investigation may be notified." However, the TennCare contract states that "all managed care organizations shall immediately report to the TBI MFCU any suspicion or knowledge of fraud and/or abuse including but not

limited to the false or fraudulent filing of claims and/or the acceptance or failure to return monies allowed or paid on claims know to be false or fraudulent".

Management's Comments:

Agree. The claims processing manual has been revised to comply with the TennCare contract by requiring any fraud to be reported to the TBI MFCU.

C. Provider Manual

The provider manual outlines written guidelines to the provider to assure that the claims are processed accurately and timely. In addition, the provider manual informs the providers of the correct procedures to follow in the event of a disputed claim. A review of OHP's Provider Manual revealed no weaknesses.

VIII. REPORT OF FINDINGS AND ANALYSES – FINANCIAL REVIEW

A. Financial Overview

OHP files annual and quarterly statements with the Tennessee Department of Commerce and Insurance. The department uses the information filed on these reports to determine if the managed care organization meets the minimum requirements for statutory reserves. The statements are filed on a statutory basis of accounting. Statutory accounting differs from generally accepted accounting principles because "admitted" assets must be easily converted to cash to pay for outstanding claims. "Non-admitted" assets such as furniture, equipment, and prepaid expenses are not to be included in the determination of plan assets and should be reduced from equity. Additionally, T.C.A. § 56-32-212(5) defines the term "admitted assets" for the purposes of calculating a health maintenance organization's net worth.

On the first amended NAIC Statement for the quarter ended June 30, 2000, OHP reported $11,782,762 in admitted assets, $8,663,833 in liabilities and $3,118,929 net worth. OHP reported total revenues of $40,978,360, and total expenses of $43,636,330 resulting in a net loss of $2,657,969 for the period January 1 through June 30, 2000. Revenue consists of $40,404,590 in capitation payments from the TennCare Program, $510,515 in investment income, and $63,256 in other revenue. The plan reported $36,954,081 in medical and hospital expenses and $6,682,248 in administrative expenses. Premium taxes paid to the State were reported as $808,080. Medical and hospital expenses represent 91.5% of capitation payments from TennCare, and administrative expenses less premium taxes represent 14.5% of capitation fee payments from TennCare.

The results of the financial tests performed revealed several discrepancies in OHP's preparation of the NAIC Statement for the quarter ended June 30, 2000 (see Results of Financial Tests Performed). As a result of examination testwork, TDCI adjusted OHP's net worth as of June 30, 2000 from $3,118,929 to $4,000,964 resulting in a statutory net worth excess of $1,102,427 (see Schedule of Examination Adjustments to Net Worth).

B. Financial Tests Performed

TDCI reviewed the account balances on the NAIC Statement for the quarter ended June 30, 2000 to determine if balance sheet and income statement amounts were properly reported as required by NAIC guidelines and Tennessee Code Annotated. This review included the following tests:

- The independent auditors' report for the year ended June 30, 2000 was reconciled to NAIC Statement for the quarter ended June 30, 2000.
- Cash and cash equivalents balances were verified through bank statements and bank reconciliations.
- Investment balances were confirmed against investment statements.
- Receivables were reviewed for admittance purposes under NAIC guidelines.
- Claims payable was reviewed for adequacy. This was accomplished by determining total medical payments subsequent to the period for dates of service during the reporting period.
- Other payables were reviewed for accuracy.
- Premium revenue was verified through documentation of payments from the TennCare Bureau.
- Other revenues were reviewed for accuracy.
- Medical expenses were reviewed for accuracy through testing of payments by the claims processing system and capitation payments to providers. Effective July 1, 2000, the TennCare contract requires OHP to pay medical providers at least 85% of the TennCare capitation payments for the provision of medical services. Additional tests were performed to ensure that medical expenses were recorded in the proper period for the 85% provision.

- Administration expenses were reviewed for accuracy. Management fee payments were recalculated per the management agreement with UA-TN.

- Events subsequent to the reporting period were reviewed for effect on account balances as of June 30, 2000.

C. Results of Financial Test Work Performed

1. Adjustments Resulting from Independent Auditors' Report

On September 7, 2000, OHP originally submitted the Quarterly NAIC Statement for the quarter ended June 30, 2000. The original statement reported net worth of $3,030,590. As a result of the independent audit for the fiscal year ended June 30, 2000, claims payable as reported was increased by $811,661 to a reported amount of $8,011,007. Net worth was adjusted to $2,218,929. T.C.A. § 56-32-212(a)(2) requires HMOs to maintain a minimum net worth of 4% of the first $150,000,000 in annual premium revenue on the most recent annual statement filed and 1.5% of the annual premium revenue in excess of $150,000,000. Based on the total premium revenue reported on the NAIC Annual Statement for the year ended December 31, 1999 of $72,463,427, the minimum net worth requirement was $2,898,537 as of June 30, 2000. Based on the adjusted net worth as a result of the independent auditor's adjustment to claims payable, OHP had a statutory net worth deficiency of $679,608 as of June 30, 2000. On September 12, 2000, the UA-TN board approved the purchase of $900,000 in shares of Series A preferred stock in OHP to fund the statutory net worth deficiency. TDCI examiners verified the cash transaction during the on-site examination. OHP amended the NAIC Statement for the quarter ended June 30, 2000 on December 4, 2000. Claims payable was increased based on the independent auditor's certification. Additionally, OHP recorded a receivable due from affiliates of $900,000. The changes from the original statement to the amended statement resulted in adjusted net worth of $3,118,929, $220,392 in excess of the minimum required.

Management's Comments:

The original NAIC Statement was filed prior to the receipt of the actuarial report. Once the report was received, the appropriate adjustments were made to bring OHP into statutory compliance.

2. Claims Payable and Provider Contingent Liabilities

As previously discussed, the claims payable was adjusted to $8,011,007 based upon certification of the claims payable by the independent auditor. TDCI reviewed payments by the claims processing system and non-system payments for dates of service through June 30, 2000. The claims processing system has paid through June 30, 2001 a total of $6,875,840 for dates of service through June 30, 2000. Non-system payments consisting of settlements, primary cap payments, Doral capitation payments, and MIM pharmacy cap payments paid after June 30, 2000 for dates of service through June 30, 2000 totaled $347,043. After considering system and non-system payments through June 30, 2001, the remaining claims payable for June 30, 2000 is $788,124.

A hospital provider filed an action in Chancery Court for breach of contract for an unspecified amount against OHP on February 18, 2000. The action states OHP breached its contract with the provider for failing to pay the difference between the hospital provider's billed charges and amounts paid by OHP to the hospital provider. The decision reached in this action could effect the adequacy of the amounts reported as claims payable for June 30, 2000 with a remaining balance of $788,124 as of June 30, 2001.

3. Medical Loss Ratio Reports

Effective July 1, 2000, Section 3-10.c.1 of the TennCare contract requires all TennCare MCOs "… to achieve an annual medical loss ratio of no less than 85% of capitation payments received from TENNCARE based on a fiscal year as an accountability measure for Fiscal Year 2001 while new accountability measures are being developed. …The intent of the 85% medical loss ratio is that 85% of the capitation rate will be spent on covered medical services for eligible TennCare enrollees."

Examiners tested the medical loss ratio reports to ensure medical expenses were allowable under the definition of medical expenses as defined in Section 1-3 of the TennCare Contract. These tests included ensuring that administrative costs of subcontractors were excluded from the calculation of the medical loss ratio. Medical expenses were verified by testing payments by the claims processing systems and other non-system payments for dates of service after July 1, 2000 through September 30, 2000.

The following discrepancies were noted in OHP's calculation of the medical loss ratio through testing of medical loss ratio reports filed through September 30, 2000:

- The Incurred But Not Reported (IBNR) component of the medical loss ratio report was not based on actuarial studies or historical payment patterns of medical claims. Instead, OHP reported IBNR to be an amount that would cause the medical loss ratio report to equal 85% for the reporting months July through September 30, 2000.

- Administrative costs of $23,500 related to the claims processing fee of a pharmacy subcontractor was improperly included in the medical loss ratio report as medical expenses.

- Drug payments of $90,407 related to dates of service prior to July 1, 2000 were improperly included in the medical loss ratio report as medical expenses.

- OHP has filed a medical loss ratio report as of June 30, 2001. For the fiscal year, OHP reported a medical loss ratio of 87.1%. A final assessment of OHP's medical loss ratio will be required within ninety (90) days after the fiscal year (September 30, 2001).

Management's Comments:

It is our position that the MLR has to be 85% as required by contract. Interim statements for the period ending 09/30/00 reflect IBNR estimates which were adjusted when actuary studies were performed in December 2000 and June 2001.

TDCI's Rebuttal:

Per the TennCare contract, OHP is correct that an actuarial certification is required for IBNR/Claims payable for June 30, and December 31, NAIC statements. However, interim reporting of IBNR/Claims Payable should be based on historical payment patterns. OHP had simply computed IBNR/Claims Payable as the difference between 85% of capitation payments for the reporting period less actual cash payments for the reporting period. By computing IBNR/Claims Payable based on historical payment patterns, OHP would be better able to monitor fluctuations of the Medical Loss Ratios.

4. Allocation of Management Fee Expenses

As previously discussed, UA-TN, OHP's parent, contracts with OHP to manage the operations of the HMO. Per the Addendum to the Management Agreement effective July 1998, the management fee was 13% of premium payments and all

interest (gross revenue) earned by OHP. The management fee expense of $5,761,170 for the period January 1 through June 30, 2000 was properly computed according to the management agreement in effect during that period. The management fees are allocated to line item expense categories and reported on Report 2A of the Second Quarter 2000 NAIC Statement based upon the direct expenses incurred by UA/TN. The excess of management fee charged to OHP versus the actual management expenses is $437,296 and is reported as "Other Unassigned" expense as of June 30, 2000.

5. Material Modification of the Management Agreement

On September 12, 2000, subsequent to the examination period, OHP amended the management agreement with UA-TN effective October 1, 2000 to decrease the management fee to 12% of premium payments and 15% of interest earned until such time as OHP's enrollment increased to at least 55,000. At an enrollment level of 55,000, the management fee decreased to 11% of premium payments and 15% of interest earned by OHP. During June 2001, OHP's enrollment exceeded 55,000, thus OHP lowered the management paid to UA-TN in that month. Effective July 1, 2001, the management fee was decreased again to 10% of TennCare premiums plus 15% of interest earned because OHP's enrollment exceeded 70,000 members at that point.

OHP's management agreement with UA-TN was amended to reflect these decreases in the management fee calculations. These amendments to the management agreement are considered material modifications of OHP's certificate of authority pursuant to T.C.A. § 56-32-203(c); however, OHP has not made the required statutory filing to obtain prior approval by TDCI of this material modification of an operational document.

Management's Comments:

Effective September, 2000 the management agreement was amended to reduce the management fee paid by OmniCare Health Plan, Inc. OHP will notify TDCI of any future modifications to the management agreement.

TDCI's Rebuttal:

OHP is required by statute to obtain approval from TDCI for the prior modifications to the management agreement as well as prior approval from TDCI of any proposed amendments to the management agreement.

6. Cash and Short Term Investments

   As of June 30, 2000, OHP reported cash as an admitted asset of $4,786,789. This balance incorrectly includes $252,222 of funds held in escrow by providers. The funds were eventually returned to OHP. Under NAIC guidelines funds held in escrow are not readily available for the payment of claims and therefore should be classified as non-admitted assets.

   Management's Comments:

   These funds have been received from the providers as of 02/28/01.

7. Restricted Deposit

   OHP maintained a restricted deposit with a maturity value of $1,500,000 at June 30, 2000, to satisfy requirements of T.C.A. § 56-32-212(b)(3). The funds are invested in debt securities with federal government agencies with a fair value of $1,478,472.

8. Premium Receivable and TennCare Premium Revenue

   OHP reported premium receivables of $2,274,302 as of June 30, 2000 and TennCare premium revenue of $40,404,590 for the period January 1 through June 30, 2000.

   The premium receivable consists of $906,289 for monthly withholds by the TennCare Bureau and an estimate of $1,566,014 for adverse selection payments. The withholds were returned in July 2000. The estimate for adverse selection payments was understated by $135,628 based on the final payments by the TennCare Bureau related to periods through June 30, 2000. Net worth will be increased by $135,628 for additional adverse selection payments.

   On February 14, 2001, the TennCare Bureau made a payment of $843,601 to OHP for capitation payments for retroactive enrollment for calendar years 1996 through 1999. Net worth will be increased by $843,601 for retroactive enrollment payments.

   Premium revenue through June 30, 2000 incorrectly includes $6,200 relative to liquidated damages withheld from TennCare capitation payments that were improperly accrued in 1999. Net worth will be decreased by $6,200 for the error in reported premium revenues.

Management's Comments:

The December 1999 annual statement was revised to reflect the $6,200 adjustment.

9. Other Accounts Receivable

OHP reported and admitted the following accounts receivable (A/R) as of June 30, 2000: A/R Other $8,340, A/R Reinsurance $103,200, and A/R Providers $295,954.

The A/R Other was received in July 2000. OHP actually collected reinsurance recoveries of $204,960 more than the accounts receivable reported. The A/R Providers was aged on Schedule G-1 Health Care Receivables of the Quarterly Statement with amounts over 90 days non-admitted for NAIC Statement reporting. No evidence was provided by OHP that the A/R Providers was eventually collected.

Net worth will be increased by $204,690 for additional reinsurance recoveries. Net worth will be decreased by $295,954 for uncollected accounts receivable from providers.

Management's Comments:

Accounts receivable due from providers decreased by the amount of various claims filed by the providers in subsequent months.

10. Working Capital

OHP must establish and maintain a positive working capital defined as current assets greater than current liabilities per T.C.A. § 56-32-212(a)(6). OHP's current assets exceed current liabilities at June 30, 2000.

D. Schedule of Examination Adjustments to Net Worth

Statutory net worth as reported in original NAIC Statement for the quarter ended June 30, 2000	$3,030,590
Less: Independent auditor's adjustment to medical claims payable	($811,661)
Add: Capital infusion for the purchase of preferred stock to fund the statutory net worth deficiency	$900,000
Statutory net worth as reported on the amended NAIC Statement for the quarter ended June 30, 2000	$3,118,929
Add: Retroactive enrollment payment in February 2001	$843,601
Add: Under accrual of adverse selection receivable	$135,628
Less: Error in Reported Premiums	($6,200)
Add: Additional reinsurance recoveries receivable	$204,960
Less: A\R Provider Advances Unsupported	($295,954)
Adjusted net worth based on examination adjustments	$4,000,964
Statutory net worth requirement as of June	

30, 2000	$2,898,537
Statutory Net Worth Excess as of June 30, 2000	**$1,102,427**

IX. TITLE VI

Effective July 1996, Section 2-25 of the TennCare Contract required OHP to demonstrate compliance with Federal Title VI of the 1964 Civil Rights Act that prohibits discrimination based on race, color or national origin. Based on discussions with various OHP staff and a review of policies and related supporting documentation, OHP was found to be in compliance with Section 2-25 of the TennCare Contract.

The examiners hereby acknowledge the courtesy and cooperation of the officers and employees of OHP.